Statement of Claire C. McCaskill

Thank you Chairman Grassley, Senator Breaux and distinguished committee members for inviting me to this hearing and including us in your efforts to improve the care for our nation's elderly. As you are aware, our audit staff is producing significant work revealing the reality of care in Missouri's nursing homes.

We released our most substantial review so far in March 2000 with our audit of Missouri's Division of Aging, which monitors Missouri's nursing homes. We found that Missouri residents *cannot* completely depend on the state to ensure quality care for their loved ones and should take it upon themselves to inspect, monitor or review a home for family members. Our report mirrors many findings of federal auditors working on behalf of your committee and exposing the systemic nature of our nation's quality of care issues.

Since our report, several improvements have occurred because of changes on both the federal and state level, but we are still far from where we want to be. We realize that the responsibility to fix the problems lay in both federal and state hands and we are thankful for this committee's work.

To help the committee aid states charged with the arduous task of monitoring nursing homes, I will briefly share the results of our review, our recommendations, and the improvements thus far. I will also update committee members on the effects in Missouri of new federal initiatives to shed light on what is working for Missouri, and what is not. Finally, I will preview our current task of delving into the complex financing of Missouri's nursing home industry.

Our audit highlighted five areas: inspections, complaint investigation and follow-up, repeat deficiencies and sanctions, staffing levels and disqualified employees. What follows is a brief synopsis of our top concerns for each area. In many instances, the "results" mentioned are improvements division officials have said they have made. We have not yet gone back and audited these statements.

INSPECTIONS:

Predictable

Finding: Despite federal and state regulations that inspections be a "surprise," we found facilities could predict the next inspection time. Division officials said that due to the predictability, it was "common practice" to make cosmetic changes and add staff beforehand. Division officials acknowledged that this practice skews the picture of facility staffing. Our concern is the practice may mask underlying problems. Division officials said the federal requirement to revisit a facility after it claims to have corrected deficiencies has also increased the predictability of the visits.

Recommendation: Continue to develop policies to reduce predictability.

Results so far:

- The division adopted a new inspection scheduling policy *before* our audit began requiring regions to vary inspections dates of homes in the same vicinity.
- Division officials said inspectors start at least 10 percent of their inspections in the evenings, nights or weekends.
- In July 2000, directors required managers to establish a schedule and introduce "random" changes throughout the year.

Minimum Number Not Met

Finding: Despite a state law requiring two inspections a year, we found the division could not make this minimum number, much less perform additional inspections. In 1999, the division failed to conduct 416 of the required inspections. Of the uninspected facilities, 23 homes had at least two notices of noncompliance - the state-level equivalent to a federal sanction. Looking back to 1996, there were no inspection records at all for at least two facilities.

Recommendations: Perform all inspections required by law. Develop a centralized inspection monitoring system, in which inspection data is entered timely, to better track and document inspections.

Results so far:

- In fiscal year 2000, the division, without increasing staff exceeded its goal of completing one inspection in each facility. The department did not complete the state requirement of two inspections in either 1999 or 2000. But the numbers of required second inspections did increase from 64 percent in 1999 to 96 percent in 2000.
- Received funding for 27 new employees in 2001 to help with inspections.
- Noting shortcomings in federal OSCAR data, the division created a new centralized database to support all primary agency operations and meet federal and state data collection requirements. The new system is being tested now.

Federal Comparative Data Not Used

Finding: The division had not studied federal OSCAR summary reports in detail and could not explain why a specific region's average cite rate for deficiencies was lower than the national average or the variation in cite rate by region (i.e. Southwest Missouri had 3.36 cites per facility, compared to 7.25 cites per facility in Northwest Missouri). Industry officials and advocates for the elderly said their most significant concerns with the division's inspection program are inconsistency, variation in interpretation and enforcement between regions.

Recommendation: Analyze available reports of deficiency patterns to note areas of weak enforcement.

Results so far:

- Division officials said they use OSCAR data as a starting point (although we found little evidence of this), but find the data unreliable "as a predictor of survey staff ability or facility status."
- The division has created an intranet Web page offering to managers HCFA statistical reports and new division-generated reports analyzing survey activities and citation patterns by region.

Inspectors Need Training

Findings:

- Similar to November 1999 GAO findings, Missouri nursing home inspectors flag more violations when accompanied by federal inspectors. Of the 31 facilities that had a federal observational survey, 308 deficiencies were cited during the federal survey, as compared to 208 by the previous division inspection. One facility increased from 5 to 45 deficiencies.
- After looking at statements of deficiencies, we found two statements that were extensively

changed after facilities disputed them. One facility originally had 11 federal and 9 state violations, but was later declared deficiency-free. A division official said these residents were so impaired, confused or demented that their statements were unreliable.

Recommendations: Ensure inspectors are adequately trained and supervised and require the informal dispute process to be followed when facilities appeal statements. Adequately document changes to statements of deficiencies.

Results so far:

- In 2001, the division will institute the new national Preceptor's Training Program to keep surveyor training consistent. Annual training will also include 24 hours of "investigative skills" including interview techniques and documenting facts.
- The division has also studied its administrative review process and "strengthened internal and management controls over documentation requirements."

COMPLAINT INVESTIGATION

Investigations Not Timely

Findings:

- Complaints are not investigated in a timely manner. Despite state law and division policy that requires an investigation to start within 24 hours of an abuse allegation or violation that puts a resident in imminent danger, about 6 percent of these investigations were not started in that timeframe. A delayed start makes it more difficult to determine if a violation occurred.
- After looking at a list of overdue complaints, more than 1,200 were at least 120 days past due, including 108 received in 1997. Overdue reports are given a low priority and many citizens complained that the division did not respond to them.
- We also noted five cases in one regional office in which a letter to the resident's family, as required by state law, was never sent because the report was so overdue.

Recommendations: Ensure complaints are initiated and completed timely, the results are submitted timely to ensure appropriate enforcement actions, the required reports are available to the pubic and a resident's family is notified with the results of all complaint investigations. Study the merits of creating a process for dissatisfied complainants to appeal the results of an investigation.

Results so far:

- The division called for "sweeping revisions" to its complaint process in 1996 (before our audit) and has repeatedly requested additional staff since 1998 to implement the revisions. Some of these requests were partially funded.
- In 2001, the division will hire 27 new employees to help with complaints and inspections
- The division is testing a new on-line system to better track and document complaints.
- The division set a new minimum requirement in mid-1999 (before our audit) that at least a call is placed to a reporter to determine the need for an immediate on-site visit.
- A central office complaint coordinator has been designated.
- Beginning September 2000, the division is monitoring quality of complaint investigations through a random selection of reports.
- Beginning September 2000, the division is testing a new Informal Dispute Resolution project to

resolve issues though face-to-face contact with the resident, their family members or guardians when the resident is the subject of a complaint.
- Division officials note that HCFA prioritizes the annual survey ahead of complaint investigations, which also affects the ability to realize the above goals. But improvement has occurred with only 400 overdue complaint reports in July 2000 as compared to more than 1,800 in July 1999.

REPEAT DEFICIENCIES, SANCTIONS

Sanctions Do Not Prevent Repeat Deficiencies

Findings:

- Of the 490 certified facilities in the state, 90 were issued a repeat deficiency for the same violation in the two most recent inspections. No federal or state sanction was issued in more than 200 inspections where a facility had 10 or more violations. And one facility had been cited for 111 problems in its last four inspections. These numbers are evidence of the roller coaster inspection process. The division cannot penalize a nursing home for a violation unless the facility fails to correct the problem within a given grace period. As a result, nursing homes are cited for problems, which they repair, only to be cited again.
- The division does not study the effectiveness past sanctions have on future compliance and does not always consider a facility's history of past noncompliance when determining sanctions. The division also does not verify that the state's Medicaid agency imposed a denial of payment sanction or whether such a sanction resulted in a fine.
- Division officials said that often when a facility has significant noncompliance, a change of ownership occurs resulting in a new license. That "new entity" then no longer carries with it the previous history of noncompliance.

Recommendation: Consider the facility's history of past noncompliance when selecting sanctions and study sanctions to determine which are most effective.

Results so far:

- Several federal changes in January have helped curbed the roller coaster problem including: allowing states to issue immediate penalties if nursing homes have repeat violations resulting in harm of just one resident, the ability of the state to impose a "per instance" civil monetary penalty with no opportunity to correct, and clarifying that a survey ensure an "on-site" visit to check for compliance rather than accepting a written statement.
- Additional federal administrative hearing staff should help with the backlog in the facilities appeal process, which has delayed the imposition of a fine for a civil monetary penalty, division officials said. Since January 2000, the division has requested a civil monetary penalty seven times and a denial of payment for new admissions 53 times.
- Division officials said the new initiatives have resulted in additional sanctions. Current numbers show federal sanctions have nearly tripled from 1997 to 2000; while state sanctions have more than doubled in the same time period. The division believes it is "too early to determine if these sanctions will have the intended effect of resulting in sustained compliance."
- The division has stopped issuing an operating license if a facility has a history of noncompliance or repeat violations. And if a complaint has not been investigated when a license is due, only a temporary permit is issued.
- The division also tried to increase its enforcement action. Officials created a graduated sanctioning process that would require automatic fine increases when repeat violations occurred.

The division proposed this extra step to HCFA, but the HCFA regional office did not feel the need to take it. HCFA officials said a denial of payment for new admission was enough to prompt a facility to correct violations. Our audit showed that denial of payment is not the most effective sanctioning tool. Several facilities with an increase in violations from one inspection to another were given a denial of payment sanction.

Civil Monetary Penalty (CMP) Works, Hard to Collect

Findings:

- We found that the imposition of civil monetary penalties (up to $10,000 a day for the most serious violation) have a greater deterrent on facility noncompliance than the sanction of denying payment for new admissions. In looking at facilities where violations significantly decreased from one inspection to another, the sanction imposed was a civil monetary penalty. And in facilities where the violations increased between inspections, the sanction was a denial of payment. Of seven facilities subjected to a civil monetary penalty, only one had a repeat violation.
- Division officials noted difficulties in collecting a state-level civil monetary penalty due to the onerous court process. Of the 25 cases filed as of August 1999, nine were filed in circuit court. But only one civil monetary penalty was collected and that was the result of a negotiated settlement.

Recommendation: Work with the legislature to modify the state CMP process and make it less burdensome, less costly and a more effective sanctioning tool.

Results so far: The division has pledged to work with the legislature.

Some Corrections Plans Do Not Stop Repeat Violations

Findings:

- Plans of Correction met state and federal requirements, but the facilities were cited for repeat violations. In these cases, it appears the facility failed to monitor compliance with the correction plan.
- Several correction plans for a repeat violation contained identical wording to the prior plan that failed.
- Some plans could not be expected to prevent a repeat deficiency. The plan only addressed the specific resident currently affected and did not incorporate a systemic change.
- If the facility was cited for insufficient staffing, the plan did not state whether the facility would add staff or provide details on staffing levels. In these cases, it is not possible to monitor whether the violation was adequately addressed.

Recommendations: The division ensure all correction plans can reasonably expect to correct the problem and not accept plans that have failed in the past. The division should develop procedures to monitor compliance with correction plans for facilities with histories of repeat violations.

Results so far:

- Division officials said new federal initiatives established in January have helped make correction plans more effective. They said the additional guidance established a definition of an "acceptable" plan. But our staff noted only one of these guidelines was actually new: that a date be set for when

the corrective action would be completed. Division officials said it is too early to tell if these modifications will result in "better and more timely" correction plans and in sustained compliance. We question whether the new guidelines are enough. Facilities should be required to self-monitor correction plans and submit regular status reports on the corrections they have made.

- •The state entity responsible for correction plans is currently recruiting for a Quality Assurance Coordinator who will manage quality assurance tasks within the division.

STAFFING LEVELS

Minimum Requirements Set Aside

Findings:

- Many complaints received by our office alleged facilities were understaffed, which resulted in inadequate care. State law requires the division to set minimum staffing requirements, but the division rescinded these minimums in 1998.
- We found a direct correlation between the number of violations and the staffing level at the five facilities we visited. The facility with the highest staffing level had two violations, while the three with the lowest staffing level had from five to nine violations. The facility with the lowest staffing level was cited in 1999 for seven violations, including two which caused actual harm.
- During inspections, the staffing levels rose up to 26 total hours per day higher than the three-month average staffing level. One facility flew in four staff members to coincide with our on-site visit.
- One facility should have been cited for a "widespread pattern" of inadequate staffing. Two residents had fallen 28 times in nearly three months and suffered 15 injuries, with at least three hospital visits. But the home was not cited for a "pattern," but rather "isolated incidents," a sanction level with no fine. Upon revisiting the facility in April 1999, the division found them in compliance. Four days after this revisit, the division received another complaint of inadequate staffing. The division returned and cited the facility for inadequate staffing. This time the division cited for a "pattern," but a pattern that did not cause "actual harm," so the facility received no further sanctions. The correction plan approved by the division set the sufficient staffing levels at the old minimum (1.85 hours per resident per day). It is difficult to understand why the division accepted this correction plan when division officials also believed the old standard was too low.

Recommendations: Establish minimum staffing ratios. Develop a system to track actual staff hours at a facility to identify potential problems. Inspectors should use recommended and actual staffing data to help identify negative resident outcomes. The division should pursue inadequate staffing levels by imposing maximum federal and state sanctions.

Results so far:

- The division disagrees with our recommendation for minimum levels and quotes a HCFA study that stated more research was necessary before determining the benefit of setting staffing minimums.
- Division officials said there are no federal or state laws requiring inspectors to use a minimum standard or industry benchmark in reviewing staff levels.
- Regarding the facility our staff thought had a pattern of inadequate staffing, division officials said the federal process prevented inspectors from considering all facts in the file and including that information in sanctioning decisions. The division is "gravely" concerned about the federal process that results in closure of incidents if the violation has been corrected. Inspectors need to

be able to include a facility's entire noncompliance history in their current inspection. Officials said although recent changes will help stop the roller coaster inspection issue, HCFA needs to make even more modifications to ensure facilities correct their system problems or stop caring for the elderly.
- The division will hire four additional auditors in this fiscal year to assist in inspections, including reviewing payroll and staffing level records.

UNSUITABLE EMPLOYEES

Employees previously abused elderly, children and mentally ill

Findings:

- We found 21 instances where a facility hired an employee named on a list of persons who have abused, neglected or exploited the elderly. In addition, more than 1,100 persons were working in nursing homes who were listed on the Department of Mental Health's disqualification listing or the Central Registry of Child Abuse and Neglect.
- A second employee match and follow-up report issued in August 2000 showed the division had improved tagging employees listed on its own disqualification list. But we still found 12 instances of current employees listed on the division's list.
- Our second match showed more than 600 instances of hiring employees named on the mental health disqualification list or the child abuse registry.
- In a subsequent report in April 2000, we advocated that the state promote a national screening system. Currently, if someone is working in Illinois and has abused the elderly, they could move to Missouri and be employed without the Illinois charge transferring to Missouri's Division of Aging disqualification list.

Recommendations: Seek legislation to prohibit employment in nursing homes of persons who have abused or neglected children or the mentally handicapped. The division should develop an automated process to note these individuals. And the division should aggressively sanction and fine facilities that make these inappropriate hires.

Results so far:

- Since our audit, the division has created an automated process to flag all persons on its disqualification lists that were inappropriately hired. Our August 2000 follow-up showed the need to fine-tune the system so the division obtains the most accurate and timely information.
- Legislators drafted bills in the 2000 session to require the division to cross-reference current employees to all three lists - aging, mental health and the child abuse registry. But the nursing home industry killed the legislation the last day of session.
- The division disagreed with our recommendation that stiff sanctions should be levied against nursing homes that hire disqualified employees.

CURRENT FEDERAL SANCTION COLLECTION

In preparation for this hearing, our staff reviewed what has been collected on current federal sanctions. This review *was not* part of our March 2000 audit of the Division of Aging.

- From 1996 to now, the division has requested civil monetary penalties against 65 homes. Fourteen of these sanctions are under appeal. In two of these appeals the time lag between the inspection

and the final determination has exceeded 18 months. Seventeen homes waived their appeal rights and received an automatic 35 percent reduction in their fine.

- Bankruptcy is still an issue with nine sanctions against seven homes uncollectible due to bankruptcy. These include five homes owned by one company.
- In four instances the civil monetary penalty decreased after an administrative review or an informal dispute resolution (IDR). In one case, the fine decreased by 95 percent. Requested sanctions were rescinded four times, three due to state administrative review or IDR and once due to a federal IDR.
- Two of the homes with uncollected fines are from sanctions filed in 1996 and 1997.
- In the 1997 case in which a home owes more than $24,000, the state Medicaid agency is ready to proceed with collection, but is waiting on word from HCFA as to when it can start collecting.
- The 1996 case involves a nearly $400,000 fine. The chain that operates that home filed for bankruptcy and the home has changed owners three times. HCFA wants the state to collect this fine and go after the new owner. State officials said they are waiting for "final authorization."
- Eleven homes received settlement agreements, which reduce the sanctions in all cases. The percentage decrease ranged from 43 percent to 87 percent.

CURRENT WORK ON MEDICAID REIMBURSEMENT

We are now reviewing the complex financing of the nursing home industry. What follows are our objectives for this study and some preliminary results.

Objectives:

- Determine if the Medicaid rates are sufficient to offset the cost of providing nursing home care. We will compare the costs noted on the 1998 cost reports to rate data.
- Determine if Missouri nursing homes are profitable. We will use the revenues and costs as reported on the 1998 cost reports making adjustments for the NFRA (Nursing Facility Reimbursement Allowance, a tax on providers) assessments, which are not included in the cost reports as an allowable cost. We will also attempt to locate profitability data from other states for comparison.
- Determine the major factors causing homes to be profitable or unprofitable. Are costs greater than rates or rates greater than costs?
- Determine how Medicaid rates and costs in Missouri compare to rates and costs in other states and to national medians.
- Determine estimates of the total cost to rebase the rates using the 1998 cost reports.
- Determine if there is a relationship between quality of care and homes having higher negative or positive differences between rates and costs. We define quality of care as whether a home was sanctioned during the cost report period or had high numbers of deficiencies in their 1998 inspection.
- Analyze various funding methods used by other states to determine if there are funding alternatives that might enhance the quality of care for Missouri nursing home residents.

Preliminary results

- We have determined that approximately 60 percent of the Medicaid days provided by nursing homes in their 1998 cost reporting year were reimbursed at less, sometimes significantly, than the costs of providing that care. We have also noted that some providers are being paid significantly more than cost.
- We have determined that in 1998 about 2/3 of Missouri nursing homes have revenues that exceed the allowable expenses (i.e. profitable based upon allowable costs).

- We have tentatively determined that homes with high overall occupancy are more likely to be profitable. We also noted that homes in metro areas are more likely to have higher occupancy. Homes in metro areas have costs significantly higher than rural homes.

CONCLUSION

Our staff will continue to press for the true picture of nursing home care in Missouri and then push to fix it. It is clear many of the new federal initiatives are helping states improve care. We expect that our continued probe into state-level nursing home issues will also improve care in Missouri. It is too early to tell how significantly the changes in federal and state regulations will enhance care or keep facilities in compliance. But we will continue to return to those monitoring the industry and review the status of such new initiatives. We would be happy to keep the committee posted on our efforts, reviews and results. Again, thank you for inviting me to address this committee and I am happy to answer your questions.